CAP/Targeted Case Management (CTCM) Request for Authorization Form

Use one provider per form.

Requested Start Date for this Authorization: ____/____/____

Type of Request: ☐ CNR/Initial ☐ Concurrent ☐ Revision
☐ Chg Provider ☐ Re-auth (discrete svc.)

Type of Care Requesting: ☐ Home and Community Support ☐ Day Support
☐ Residential Support ☐ Personal Care ☐ Respite Care ☐ TCM
☐ Enhanced PC ☐ Enhanced Respite ☐ Supported Employment
☐ Other _____

Demographics:
Member's Name: _____ Date of Birth: _____
Member's MID#: _____ Tel#: _____
Member's City/State: _____
Case Manager Name: _____ Tel#: _____
Provider of Service: _____ Provider ID#: _____
Provider Address/City/St: _____
Provider Contact Name: _____
Provider Contact Phone #: _____ Fax #: _____
LME: _____ Phone #: _____

Member's Current Location: ☐ Private Home w/ natural family
☐ Individual residence ☐ Supervised Living
☐ Group home ☐ Child foster care ☐ AFL/Therapeutic home
☐ Other _____

DSM-IV Diagnosis: (*Dx code must appear on Axis I and II)
*Axis I: 1) _____ 2) _____
*Axis II: 1) _____ 2) _____
Axis III: 1) _____ 2) _____
Current SNAP: _____
SNAP Index score: _____

Discharge Information: *(to be included upon discharge)*
Actual Discharge Date: _____/_____/_____
Primary Discharge Diagnosis: _____
Discharge SNAP: _____
Discharge Condition: ☐ Improved ☐ No Change ☐ Worse ☐ Other

Actual Discharge Residence:
☐ Home Alone ☐ Home w/ Others
☐ Shelter ☐ Correctional Facility
☐ Respite ☐ State Hospital
☐ Residential Placement ☐ Transfer to Medical
☐ Transfer to Alternate Psych. Facility ☐ Therapeutic Foster Care
☐ DD Residential Facility ☐ Independent Living/Supervised Living
☐ Nursing Home/SNF/Asst. Living
☐ Other:

Additional Information/Justification: _____

Treatment Request:

Service:	_____	DMA Service Code:	_____	Units: _____	Per Month
Service:	_____	DMA Service Code:	_____	Units: _____	Per Month
Service:	_____	DMA Service Code:	_____	Units: _____	Per Month
Service:	_____	DMA Service Code:	_____	Units: _____	Per Month
Service:	_____	DMA Service Code:	_____	Units: _____	Per Month
Service:	_____	DMA Service Code:	_____	Units: _____	Per Month

_____
Signature of Person Completing This Form Date

_____
Phone Number of Person Completing This Form